InfuCare Rx

Rheumatology IV Infusion Referral Form

of Pages Faxed: _____
Fax Referral To: 877-277-9155
Phone: 877-828-3940

Date Required: _____ Ship To: ☐ Patient ☐ MD Office ☐ Other: _____

PATIENT INFORMATION

Patient Name: _____
Address: _____
City, State, Zip: _____
Home Phone: _____
Cell Phone: _____
Date of Birth: _____ ☐ Male ☐ Female
Emergency Contact: _____ Phone: _____

PRESCRIBER INFORMATION

Prescriber Name: _____
Address: _____
City, State, Zip: _____
Phone: _____
Fax: _____
DEA #: _____ NPI #: _____
Contact Person: _____

INSURANCE INFORMATION (Please attach the front and back of insurance and prescription drug card.)

Primary Insurance: _____ ID: _____ Group: _____
Secondary Insurance: _____ ID: _____ Group: _____
Prescription Card: _____ ID: _____ BIN: _____ PCN: _____

To better serve your patient and facilitate insurance authorization, please complete the pertinent sections:

PATIENT DIAGNOSIS/CLINICAL INFORMATION

☐ M06.9 Rheumatoid Arthritis
☐ M45.9 Ankylosing Spondylitis
☐ M32.9 Systemic Lupus Erythematosus
☐ M08.00 Unspecified Juvenile Rheumatoid Arthritis
☐ L40.0 Moderate to Severe Plaque Psoriasis
☐ L40.50 Psoriatic Arthritis
☐ L40.59 Psoriasis with Arthropathy
☐ Other: _____

TB/PPD test: ☐ Positive ☐ Negative ☐ Date Read: _____
Weight: _____ ☐ kg ☐ lbs Height: _____ ☐ cm ☐ in %BSA: _____
Allergies: _____ ☐ NKDA
☐ Pharmacy to coordinate home health nursing visit as necessary: ☐ Yes ☐ No
☐ Home health nursing coordination not necessary.
Reason: ☐ MD office to administer to patient
☐ Home health nursing already coordinated

Prior Medication Failed: _____ Length of Treatment: _____ Reason for Discontinuation: _____

PRESCRIPTION INFORMATION

Medication:	Dose/Strength:	Directions:	Quantity:	Refills:
☐ Actemra®	☐ 80 mg/4ml ☐ 200 mg/10ml ☐ 400 mg/20ml	☐ Induction Dose: Infuse 4 mg/kg every 4 weeks. ☐ Maintenance Dose: Infuse up to 8 mg/kg every 4 weeks based on clinical response. ☐ Other: _____		
☐ Benlysta®	☐ 120mg/vial ☐ 400mg/vial	☐ Induction Dose: 10mg/kg. Dose = _____ mg at 2 week intervals for the first 3 doses and at 4-week intervals thereafter. Infuse IV over 1 hour. ☐ Maintenance Dose: 10mg/kg. Dose = _____ mg every 4 weeks. Infuse IV over 1 hour.		
☐ Orencia®	☐ 250mg vial	☐ Infuse _____ mg at weeks 0, 2 and 4, then every 4 weeks thereafter. ☐ Other: _____		
☐ Inflectra® ☐ Remicade® ☐ Renflexis™	☐ 100 mg vial	☐ **INITIAL:** Infuse IV _____ mg/kg (Dose _____mg) at 0, 2, and 6 weeks (Quantity: _____) ☐ **MAINTENANCE:** Infuse IV _____ mg/kg (Dose _____ mg) every _____ weeks (Quantity: _____) ☐ Other: _____ ☐ Pharmacist will round to the nearest 100 ☐ Give exact dose (do NOT round)		
☐ Rituxan®	☐ 100mg vial ☐ 500mg vial	☐ Infuse two doses of 1000 mg separated by 2 weeks. ☐ Other: _____		
☐ Simponi Aria®	☐ 50mg/4ml	☐ Infuse 2 mg/kg over 30 minutes at weeks 0 and 4, then every 8 weeks thereafter. ☐ Other: _____		
☐ Other:				

Pre-Medications & Other Medications
- Infusion supplies as per protocol
- Anaphylaxis Kit as per protocol

☐ Acetaminophen _____ mg PO prior to infusion
☐ Diphenhydramine _____ mg
☐ 250ml 0.9% NaCl for hydration ☐ PO ☐ IV
☐ Other: _____

Flush Protocol
- NaCl 0.9% 10ml
- Before and after infusion

By signing this form and using our services, you are authorizing InfuCare Rx to serve as your prior authorization designated agent in dealing with prescription and medical insurance companies.

Prescriber Signature: _____ **Date:** _____ **UPIN:** _____